Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS RADIOLOGY GROUP
PO BOX 29407
SAN ANTONIO TX 78229

Respondent Name
VALLEY FORGE INSURANCE CO

Carrier's Austin Representative
Box Number 47

MFDR Tracking Number
M4-13-0219-01

MFDR Date Received
September 21, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Copy of the explanation of benefits that shows payments were made on previous [sic] of services in relation to the injury incurred by the patient that you are now denying."

Amount in Dispute: $120.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Even after being advised of the rationale for the bill reduction, the requestor did not submit a DWC-53 identifying who the treating doctor is nor did the Requestor submit any evidentiary documentation to verify that these services were either performed b or requested by the 'primary/treating doctor'... While the requestor provided no information to identify the Treating Doctor to be Dr. Martinez or Dr. Delee, the attached documentation from Respondent is clear that the treating doctor for this claim is Dr. Bruce Begia. Again, there is no supporting evidence to establish that the disputed services were either provided by Dr. Begia or authorized by Dr. Begia. Second MRI requires pre-certification."

Response Submitted by: Law Offices of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2011	73721-26	$107.54	$0.00
February 5, 2012	73590-26	$13.38	$0.00
TOTAL		$120.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 38 – Services not provided or authorized by designated (network/primary care) providers
   - 880-149 – Denied per insurance: Treatment not approved by treating physician 100%
   - 39 – services denied at the time authorization/pre-certification was requested
   - 880-122 – Denied per insurance: Pre-authorization request was denied (Rule 133.6000) [sic] 100%
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: refer to the 835 Healthcare Policy Identification Segment if present
   - 880-287 – Unnecessary medical treatment based on ODG 100%
   - 1- (18) – Duplicate claim/service
   - 1 – This item was previously submitted and reviewed with notification of decision issued to payer, provided (duplicate invoice)
   - 2 – Reviewed: 04/30/2012 ORIG CTL Number XXXXX ORIG TOTAL RECOMMENDED ALLOWANCE $0.00
   - D – This item was previously submitted and reviewed with notification of decision issued to payor-provider

Issues

1. Did the requestor met the requirements of Division rule at 28 TAC §180.22(c) and Texas Labor Code §408.021(c)?
2. Was the request for medical fee dispute resolution for CPT code 73590-26 rendered on February 5, 2012 filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
3. Is CPT code 73590-26 rendered on February 5, 2012 eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The requestor seeks reimbursement for CPT code 73721-26 rendered on October 5, 2011, denied by the insurance carrier with denial reason codes "38 – Services not provided or authorized by designated (network/primary care) providers" and "880-149 – Denied per insurance: Treatment not approved by treating physician 100%."

   Per 28 Texas Administrative Code §180.22 "(c) The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury. The treating doctor shall: (1) except in the case of an emergency, approve or recommend all health care reasonably required that is to be rendered to the injured employee including, but not limited to, treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers, as defined in this section; (2) maintain efficient utilization of health care; (3) communicate with the injured employee, injured employee's representative, if any, employer, and insurance carrier about the injured employee's ability to work or any work restrictions on the injured employee."

   Texas Labor Code §408.021(c) states in pertinent part, "(c) Except in an emergency, all health care must be approved or recommended by the employee's treating doctor." No documentation was found to support that the disputed services were approved or recommended by the injured worker's treating physician. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §180.22(c). As a result, reimbursement for CPT code 73721-26 rendered on October 5, 2011 cannot be recommended.
2. The requestor seeks reimbursement for CPT code 73590-26 rendered on February 5, 2012, denied by the insurance carrier with denial reason code "50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: refer to the 835 Healthcare Policy Identification Segment if present."

   28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

28 Texas Administrative Code §133.307(e) (3) (G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General).

The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for CPT code 73590-26 rendered on February 5, 2012. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.

The requestor has failed to support that the CPT code 73590-26 rendered on February 5, 2012 is eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

3. For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute concerning CPT code 73590-26 rendered on February 5, 2012. As a result, no amount is ordered.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 14, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.